NORTH CAROLINA MEDICAID

Miscellaneous Drug Request Form

Request Date _____

Recipient's Medicaid ID# _____ Date of Birth _____/_____/_____

Recipient's Full Name_____

Is Recipient Medicare eligible?_____ Institutionalized?_____ Pregnancy Status? _____

Prescriber Full Name _____ Prescriber DEA # _____

Prescriber Address (mandatory) _____

City _____ State _____ Zip _____

Prescriber Telephone # _____ Prescriber Fax #_____

Prescriber E-mail Address _____

Drug : _____

Quantity: _____ Length of Therapy on Prescription_____

Dosage and frequency of dosing: _____

1. Diagnosis: _____
2. Previous therapy (include drug/dose/duration): _____
3. Reason for use of Non-formulary drug or agent requiring prior approval: _____

_____

4. Pertinent lab data (Dated within the last 3 months): _____
5. Other pertinent information: _____
6. Possible drug interactions/conflicting drug therapies: _____

Instructions to submit: (Choose one)

To Fax or Mail:

1. Form may be completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

To Email:

1. Save the form using a different filename.
2. Complete electronically.
3. Email as an attachment to ACS State Healthcare.

Send to: ACS State Healthcare, Prescription Benefits Management
Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350
Fax: (866) 246-8507
Phone: (866) 246-8505; M-F 7am-11pm, EST; S-S 7am-6pm, EST
E-mail: nc.providerrelations@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date: _____ Notified: _____

Approved: _____ Denied: _____

Reason: _____

March 2002